Cervical screening among marginalized women

STILL A LOT TO GAIN

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JADE

Experience

- Violence
- sexual trauma
- traumatic removal of children out of their custody
- (forced) prostitution
- relations for protection

Homeless women are vulnerable

housing by numbers
Housing Network

Homeless women are even more vulnerable than homeless men

Channel 4 programme shows more women are becoming homeless and being treated far worse on the streets and by councils

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Tue 14 Feb 2017
16.25 GMT

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This article is over 2 years old

▲ Channel 4's Dispatches has revealed the impact of homelessness on women. Photograph: Pro Co/Channel 4 picture publicity

Research questions

1. Incidence rate of hrHPV and ≥Pap2 among homeless women

Comparison of cervical cytology classification systems

Bethesda	CIN	Dysplasia	Papanicol.
NL	NL	NL	I
Infection , reactive,repair	Inflammatory atypia	Inflammatory atypia	II
ASC-US	Squamus+HPV atypia	Squamus+HPV atypia	IIR
LSIL	CIN I	Mild dysplasia	III
HSIL	CIN II CIN III CIN III	Moderate dyspl. Severe dyspl. Carcinoma insitu	III IV IV
SCC	SCC	SCC	V

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BSCC classification: Borderline change + hrHPV positive

Research questions

1. Incidence rate of hrHPV and ≥Pap2 (borderline change) among homeless women
2. Exploration of different approaches to engage homeless women in participation in cervical screening.

AIM: To implement a tailormade cervical cancer screening for marginalized women within the existing system.

Background

- Netherlands: Dutch registered women are invited by mail for a PAP smear at their GP, analyzed through a **trapped test** (hrHPV→cytologic analysis) every 5 years between age 30-60. Incidence rate of ≥Pap2/*Borderline change*: 3%.

- Marginalized women: many **risk factors** of chronic hrHPV, **low participation** in national screening programme, American study: **4.4 times more chance** of abnormalities, 6.6 times more chance of death of cervical carcinoma.

- Problem: no registered **address**, difficulties access to care, **no regular GP**, **fear** of payment, uninsured, sexual **trauma**, **other priorities** than preventive care.

Methods

- Design: cross-sectional screening in Rotterdam
- Population: homeless women, instable living sex workers and undocumented women, age 20-60.
- Time period: Feb 2019- May 2019
- Locations: shelters, living room projects, respite care locations, safe houses for sexual trafficking victims, during street doctor consultation hours and in brothels and sex workers walk-in houses
- Team: Female nurse and streetdoctor with a care provider of the location
- Approach: direct of indirect
- Analysis at cytologic lab of local hospital- funding

Methods analysis

- N=100, necessary n=32 based on American study.
- Comparison of incidence of hrHPV and ≥Pap2/*Borderline change* regional with the marginalized women
- Sub-analysis on age (20-30 vs 30-60) and eligibility for national screening programme
- Observations around invitation strategy and approach

Results

- Inclusion of n=74 women (early stop due to high amount of abnormalities)
- hrHPV +: 35 % (mean regional 9%)
- hrHPV and ≥Pap2/*Borderline change*: 16 % (regional 3%)

Results

- Sub-analysis: 20-30 year 25% (n=5) ≥Pap2/*Borderline change,*
  30-60 year: 18.5% (n=10) ≥Pap2/*Borderline change*.

- Sub-analysis: eligible for national screening 37/74.
  eligible: 5/37 ≥Pap2/*Borderline change*
  non-eligible: 10/37 ≥Pap2/*Borderline change*

- Direct invitation strategy 68/74 women included

- Inspiration
- Research questions
- Background
- Methods
- Results
- Conclusion
- Advise implementation
- Discussion

Conclusion

- Relative risk 5,3 of having ≥Pap2/*Borderline change* in marginalized women
- Direct strategy was found most effective

Implementation

- 20-60 year
- Pro-active, direct approach - tailormade
- Screening on location

- All female team
- Guided by local care provider
- Stepped testing, use PAP-smear, no self-test
- Back up safety net team for follow-up

- Organisation: local public health department, national screening, local hospital, streetdoctors/nurses, stakeholders around marginalized women.
- Funding: streetdoctors funding, national screening and local hospital.

Discussion

- Results in line with American study
- Representative group
- No information about how many women refused to participate
- Small study, not suited for sub-analysis
- Approaches not compared on the same locations, we used the most fitting approach on every location
- Co-testing was used, 3 cases with PAP2 and hrHPV- were found, no known follow-up
- Tailormade is very time-consuming
- Population selection is hard (European/undocumented/etc)

Implementation advise

- 20-60 year
- **Pro-active, direct approach - tailormade**
- **Screening on location**

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Thank you
for your attention